
Obesity Prevention in the Early Care and Education Setting: Successful Initiatives across a Spectrum of Opportunities

Meredith A. Reynolds, Caree Jackson Cotwright, Barbara Polhamus, Allison Gertel-Rosenberg, and Debbie Chang

The Early Care and Education (ECE) track presentations from CDC's Weight of the Nation (WON) 2012 conference showcased innovative national, state, and community obesity prevention efforts. The track was organized around CDC's "Spectrum of Opportunities" for obesity prevention in ECE (the Spectrum; Table 1),¹ which outlines a common set of opportunities that can enhance the ECE environment with respect to nutrition, breastfeeding support, physical activity, and screen time – all important areas for obesity prevention targeting young children. Participants discussed the opportunities on the spectrum that had been pursued, the obesity prevention standards and best practices that had been the emphasis of their efforts, and common steps for developing, implementing, and evaluating initiatives. This paper provides background information on why ECE is an important component of any jurisdiction's obesity prevention efforts, references for the primary national reports offering standards and best practice recommendations, an introduction to the Spectrum, and brief summaries of the WON ECE track presentations.

Why Obesity Prevention Efforts Should Target the ECE Setting

With an estimated 27% of 2-5 year olds already overweight or obese,² prevention efforts that address young children are important. One of the best places

to reach young children is the ECE setting, including preschools, child care centers, day care homes (also known as family child care), Head Start, and pre-kindergarten programs. More than 60% of children younger than 6 years are estimated to be in nonparental care on a weekly basis.³ More than 11 million spend an average of 30 hours per week in nonparental care, with children of working mothers spending almost 40 hours a week in ECE centers.⁴ ECE is included in the Surgeon General's vision for reversing obesity trends,⁵ the White House Childhood Obesity Task Force Report,⁶ and is a key pillar of First Lady Michelle Obama's national obesity prevention initiative (*Let's Move!*).⁷

ECE facilities often serve as "homes away from home" for young children due to the working demands of many U.S. families. ECE providers can help young children establish healthy eating and activity habits during a developmental phase that is especially important for habit formation.⁸ Young children are more likely than older children to be influenced by adults, and eating and activity habits acquired early can track into adulthood.⁹ Additionally, providers have opportunities to influence parents to adopt healthier practices at home.¹⁰

Meredith A. Reynolds, Ph.D., is the Applied Research and Guidelines Development Team Lead in the Obesity Prevention and Control Branch, Division of Nutrition, Physical Activity and Obesity, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention in Atlanta, GA. **Caree Jackson Cotwright, Ph.D.,** is an Assistant Professor at the College of Family and Consumer Sciences at the University of Georgia in Athens, GA. **Barbara Polhamus, Ph.D.,** is a Behavior Scientist in the Program Development and Evaluation Branch, Division of Nutrition, Physical Activity and Obesity, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention in Atlanta, GA. **Allison Gertel-Rosenberg, M.S.,** is the Director, National Prevention and Practice at Nemours in Newark, DE. **Debbie Chang, M.P.H.,** is the Vice President, Policy and Prevention at Nemours in Washington, D.C.

Table 1

Spectrum of Opportunities for Obesity Prevention in Early Care and Education

Opportunity Description	Obesity Prevention
<p>Licensing and Administrative Regulations – Licensing is permission from the state to operate an ECE facility. All programs and providers (with some exceptions) are required by law to meet state-specific minimum standards of care. In some cases, local jurisdictions can also set standards. Regulations and enforcement standards vary considerably by state.²⁹</p>	<p>Obesity prevention strategies can be incorporated into licensing and administrative regulations in several ways, including:</p> <ol style="list-style-type: none"> 1. Requiring that facilities meet specific nutrition, breastfeeding, physical activity, and screen time standards (e.g., setting a minimum number of minutes per day of physical activity); 2. Incentivizing facilities to meet standards voluntarily through a reduction in licensing fees; 3. Requiring ECE providers to obtain training, continuing education or certification in obesity prevention, including nutrition, breastfeeding, physical activity, and screen time; 4. Incorporating obesity prevention messages and standards into coursework, training, and education requirements for ECE providers; and 5. Enacting new state regulations requiring all ECE facilities to meet Child and Adult Care Food Program standards, regardless of participation in the program.
<p>Child and Adult Care Food Program (CACFP) – CACFP is a federal nutrition assistance entitlement program that provides reimbursement for meals and snacks served to more than 3.3 million children each day as part of the day care they receive.³⁰ CACFP regulates meal patterns and portion sizes, provides nutrition education, and offers sample menus and training in meal planning and preparation to help ECE providers comply with nutrition standards. Most legally operating ECE facilities, including centers and family-homes, are eligible to participate in CACFP.</p>	<p>States can use CACFP to help promote healthy eating and decrease obesity in young children in ECE by:</p> <ol style="list-style-type: none"> 1. Providing CACFP training and technical assistance focused on nutrition, breastfeeding, physical activity, and screen time education for children, teachers, and parents; 2. Enhancing state CACFP standards to align with other national nutrition guidelines such as the U.S. Dietary Guidelines for Americans; and 3. Providing information on how to increase CACFP participation among facilities.
<p>Quality Rating and Improvement Systems (QRIS) A QRIS is a systemic approach to assess, communicate, and improve the level of quality in early childhood and school-age care and education programs.³¹ Through QRIS, states define what constitutes a higher quality of care based on designated criteria and use a rating system with a recognizable and understandable symbol to communicate to the public how well participating ECE facilities meet these criteria. QRIS is often linked to child care subsidy reimbursement rates. Additionally, QRIS uses licensing and administrative regulations as a baseline to define what constitutes improved quality. QRIS is often linked to enhanced training, professional development, qualifications, and program accreditation.</p>	<p>Obesity prevention strategies can be incorporated into QRIS by:</p> <ol style="list-style-type: none"> 1. Designating specific nutrition, breastfeeding, physical activity, or screen time standards needed to reach higher quality ratings (e.g., setting a minimum number of minutes per day of physical activity above what is required in state licensing regulations); 2. Requiring participating providers to conduct a systematic assessment of their policies and practices related to obesity prevention, such as the assessment included in the Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC) intervention;³² 3. Including obesity prevention-specific technical assistance activities in the set of materials and resources that programs participating in QRIS receive; and 4. Incorporating obesity prevention information into coursework training and education requirements for child care providers.
<p>Funding and Finance – States, through their general funds, typically invest in ECE over and above the allocations they receive from several federal government programs (e.g., Child Care and Development Fund, Temporary Assistance for Needy Families, Head Start, Social Service Block Grants, CACFP, and Maternal and Child Health Block Grants). As of FY 2011, states were appropriating \$18.5 billion of state funds to ECE for services such as child care, pre-K, home visiting, and other early learning strategies.³³ In many states, the department of education and local school districts provide funds to support preschool and afterschool child care providers and expand Head Start programs. In some states, the legislature has authorized state funds to develop QRIS for ECE.</p>	<p>States can use their authority to set standards for the CCDF and SSBG to enhance requirements for healthy eating, breastfeeding support, physical activity, and reduced screen time. They can also require parent education and engagement in obesity prevention efforts. States can require or incentivize ECE providers that receive TANF/CCDF subsidies to implement obesity prevention policies and programs as a condition for participation. Additionally, states can use their MCHBG to provide training and technical assistance for ECE providers and to help implement various obesity prevention interventions.</p>

Opportunity Description	Obesity Prevention
<p>Pre-service and Professional Development – Pre-service training, also known as certification in some states, refers to a program or series of trainings required for adults to become ECE providers and work in a state-governed ECE facility. Professional development refers to ongoing professional training for current ECE providers. States typically specify how often and how many continuing education credits must be earned and the content areas for training in their licensing and administrative regulations. Many states specify a set of core knowledge and competencies that define what effective ECE providers should understand and be able to do in order to be effective in their role.³⁴</p>	<p>Ways to incorporate obesity prevention strategies into ECE provider pre-service and professional development training for ECE providers include:</p> <ol style="list-style-type: none"> 1. Ensuring that educators of ECE professionals are trained on nutrition, breastfeeding, physical activity, and screen time and that early childhood degree programs include this material in required coursework; 2. Offering optional coursework in obesity prevention for those students interested in learning more about adult and child health; 3. Requiring that state certification and continuing education programs incorporate nutrition, breastfeeding, physical activity, and screen time messages; and 4. Offering optional training in obesity prevention for certification and continuing education programs for those providers interested in going beyond minimum requirements. This can be incorporated as part of a state QRIS or special designation for providers and facilities.
<p>Facility-Level Interventions – Facility-level interventions are any programs or initiatives that encompass a defined set of activities that take place directly within ECE facilities. They may seek to alter policies and practices within the facility or to support behavior change in children directly. Interventions may specifically target one aspect of obesity prevention, such as breastfeeding support, or may be comprehensive to include nutrition, breastfeeding, physical activity, and screen time. Interventions can entail a single component, such as a curriculum, or have multiple components that are mutually reinforcing.</p>	<p>Numerous facility-level interventions, especially curricula, are available to help promote nutrition, breastfeeding, physical activity, and limit screen time in young children in ECE including, to name a few: Color Me Healthy;³⁵ Grow it, Try it, Like it;³⁶ I am Moving, I am Learning;³⁷ the Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC);³⁸ and Eat Well, Play Hard in Child Care.³⁹ These interventions may differ fundamentally in their approach, but when used together, can complement one another and provide a more comprehensive approach to childhood obesity prevention.</p>
<p>Technical Assistance – Within the context of ECE, technical assistance is the provision of expert advice and guidance to ECE providers to improve the quality of care provided by changing practices. It typically encompasses observation, assessments, support, and monitoring.⁴⁰ Each state has a child care resource and referral (CCR&R) agency through which ECE facilities can access technical assistance providers. Technical assistance may also be provided by staff from the state licensing agency and the Child and Adult Care Food Program as well as by Child Care Health Consultants, Cooperative Extension agents, physicians, county and state nutritionists, and health department nurses.</p>	<p>Nutrition professionals can provide technical assistance to ECE programs on menu planning, nutritional assessment of meals and snacks, training for foodservice personnel, and nutrition education for ECE providers, children, and families. Experts in physical activity can help ECE providers promote energy expenditure in young children through active play and reduced screen time.</p>
<p>Access to Healthy Environments – Access to nutritious foods and space for active play is essential if ECE providers are to comply with enhanced regulations, QRIS, and facility-level interventions that support obesity prevention efforts.</p>	<p>States and communities can promote access to healthy environments for children in ECE facilities and their families in a number of ways, including through joint use agreements, farm to preschool initiatives, and centralized kitchens that provide affordable, nutritious meals to ECE facilities in a defined geographical area.</p>
<p>Early Learning Standards – Nearly every state has adopted standards for ECE to provide a framework on content areas that must be taught and assessed in young children birth to 5 years of age. State ECE agencies or state departments of education typically oversee curricula and educational programs provided to ECE facilities, especially state-administered ECE programs, to prepare young children for entry to school.</p>	<p>As state agencies create new or revise existing early learning standards, opportunities exist to emphasize nutrition, breastfeeding, physical activity, and screen time.</p>

Opportunity Description	Obesity Prevention
Family Engagement refers to the active collaboration and commitment between families and their ECE providers.	Family engagement is not so much a distinct mechanism for achieving obesity prevention strategies in ECE but rather, a critical component for implementation of changes carried out through the other opportunities. Families are essential partners when it comes to promoting the health of children, as they have a great deal of influence over the food and physical activity choices available to children and are primary role models for children's behavior – especially for children younger than 5 years of age. Strong family engagement will help ensure successful implementation of policy and practice changes to promote obesity prevention in ECE pursued through the spectrum of opportunities and can produce ripple effects with respect to improving home environments and families' behaviors.
Emerging Opportunities – Other unique opportunities for improving nutrition, breastfeeding, physical activity, and screen time policies and practices in ECE settings may exist that are unique to a specific state or community based on how the ECE system operates.	

Standards and Recommendations for Obesity Prevention in ECE

Many factors influence children's risk for unhealthy weight gain and obesity. Evidence-based standards and practices have been identified to address these factors by improving the environments in which young children spend their time, particularly the ECE setting. Four key reports detail these standards and practices: *Accelerating Progress in Obesity Prevention*,¹¹ *Early Childhood Obesity Prevention Policies*,¹² and *Child and Adult Care Food Program: Aligning Dietary Guidance for All*¹³ — all reports released by the Institute of Medicine; and *Preventing Childhood Obesity in Early Care and Education Programs: Selected Standards from Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs, 3rd ed.*,¹⁴ co-authored by the American Academy of Pediatrics, the American Public Health Association, and the National Resource Center for Health and Safety in Child Care and Early Education. Together, these reports highlight the need for obesity efforts in ECE to comprehensively target nutrition, breastfeeding support, physical activity, and screen time standards and practices. State and community efforts can systematically support the successful implementation of these standards and practices by ECE facilities in their jurisdictions.

A Spectrum of Opportunities for Obesity Prevention in ECE (The Spectrum)

Despite significant variation across states and communities in how the ECE system is organized and operated, there is a common set of opportunities by which most jurisdictions can support and incentivize the adoption of standards and practices for obesity

prevention within the ECE setting. Each opportunity, briefly described in Table 1, is a unique approach that states or communities can utilize to improve the ECE environment. Not all opportunities need be pursued or integrated in any given jurisdiction to achieve impact. Experts generally agree that it is likely that multiple opportunities pursued as a coordinated approach will be most effective at achieving a state's or community's goals for the successful implementation of obesity prevention standards and best practices by ECE facilities. Multiple factors determine which opportunities are viable at any given time and a variety of data are useful for assessing these factors. Efforts should build on existing obesity prevention efforts that have been successful pursued within a given jurisdiction, as well as existing efforts aimed at improving the quality of the ECE system. As such, a broad group of partners are relevant for planning and implementing these efforts.¹⁵

WON ECE Track Presentation Summaries

The ECE Track showcased opportunities pursued successfully in specific states and communities and featured related national initiatives. A training session and two panels featured eight statewide initiatives (AZ, CA, DE, NY, OH, RI, SC, and WI); a third panel featured the work of Jefferson County (AL), the YMCA, and the National Farm to Preschool network; and a fourth panel examined state preemption of local jurisdiction-level regulations and presented preliminary evaluation data from regulations made in New York City and Chicago. Elements of success highlighted by presenters included:

The Public Health Law Center is performing a legal review of all 50 states' statutes and regulations pertaining to ECE to (1) preliminarily assess local government's ability to establish standards for ECE settings to inform state and local obesity prevention efforts; (2) code and catalogue the obesity prevention components contained in each state's licensing laws; and (3) identify innovative practices in local ECE standard-setting. The Public Health Law Center's preliminary findings suggest that local governments have potential to both formally and informally regulate in these settings.

1. strong partnerships encompassing the diverse array of public and private ECE stakeholders to engage in the assessment, development, and decision-making process;
2. systematic assessment of opportunities and likelihood of success;
3. early and periodic assessment of ECE providers needs and wants;
4. addressing provider needs through resource provision, training and technical assistance, easy-to-use materials and special consideration for the ECE workforce especially in low-income communities;
5. provision of incentives (e.g., CEUs/annual training hours; desirable equipment/supplies related to obesity prevention);
6. being intentional and proactive based on assessment data, yet nimble enough to take advantage of unforeseen opportunities;
7. clear and consistent messaging to providers and parents that includes the rationale for policy and practice changes;
8. the use of social marketing to accelerate changes;
9. peer sharing that allows providers to learn from each other's experience;
10. using facility-level interventions to plant seeds for practice change followed by jurisdiction-level policy efforts (licensing, CACFP, QRIS) to support and sustain practice change;
11. providing training and user friendly materials for licensing, CACFP, QRIS staff, particularly with respect to monitoring compliance; and
12. focusing on spread and scale and reaching large groups of children.

Common challenges discussed included:

1. perceived and real higher costs of healthier food;
2. lack of knowledge and need for training and technical assistance on developing menus with variety, modifying recipes to meet better standards, and leading structured physical activity;
3. unhealthy food and beverages brought with children from home;
4. parent resistance and lack of engagement, particularly if changes are perceived to be driven by 'cost-cutting' considerations;
5. limited outdoor play space;
6. limited indoor play space, especially in areas where inclement weather is common;
7. resource scarcity;
8. engaging ECE providers and parents, particularly those who are overweight/obese, to consistently model healthy behaviors; and
9. fostering better collaboration between providers and parents.

National-Level Initiatives Presentation Summaries

Legal Analysis of State Preemption of Local ECE Regulation

The Public Health Law Center is performing a legal review of all 50 states' statutes and regulations pertaining to ECE to (1) preliminarily assess local government's ability to establish standards for ECE facilities to inform state and local obesity prevention efforts; (2) code and catalogue the obesity prevention components contained in each state's licensing laws; and (3) identify innovative practices in local ECE standard-setting. The Public Health Law Center's preliminary findings suggest that local governments have potential to both formally and informally regulate in these settings. For additional information, go to: <http://>

www.publichealthlawcenter.org/topics/healthy-eating/child-care>.

YMCA (Y)

In 2011, the Y made a formal commitment through the Partnership for a Healthier America to adopt standards for nutrition, breastfeeding support, physical activity, screen time, and parent education for all of their ECE and afterschool programs across the nation. Additionally, through a variety of partnerships, the Y implements community-level initiatives across the nation to help communities develop environments that support healthy eating and physical activity in the places where people live, work, learn, and play, including the ECE setting. These initiatives are guided by the Y's "Community Healthy Living Index" (CHLI), a set of tools that outline a process for change, engage stakeholders, and assist in improvement planning and implementation. The experience of Chattanooga, Tennessee provided a case example of how communities can help ECE providers to improve policies and practices to promote children's health using facility-level interventions and highlighted the challenge of building confidence among providers to model healthy physical activity behaviors. For additional information, go to: <<http://www.ymca.net/communityhealthylivingindex/>>.

National Farm to Preschool (F2PS) Initiative

F2PS refers to activities that connect ECE facilities to local food producers to benefit young children access to and interest in healthy foods and strengthen the local food system. These activities aim to cultivate healthy habits in children by promoting nutritious meals and snacks and providing experiential learning opportunities. Although F2PS is considered a type of access opportunity on the Spectrum, it typically includes facility-level interventions and family engagement efforts. A Subcommittee of the National Farm to School Network champions F2PS efforts by promoting wellness policy development and implementation; local food sourcing and farm cooperatives; scratch cooking by large distributors; farmers' markets and farm direct programs. The network maintains an online clearinghouse of resources for states and communities to develop F2PS networks and showcases successful programs, including the Occidental College program, which created curricula integrating in-class activities, gardens, interactive taste tests, parent workshops, field trips, facility-level wellness and menu policies, and a market basket program. For additional information, go to: <<http://farmtopreschool.org/>>.

State-Level Initiatives Panels and Training Presentation Summaries

Arizona

Taking advantage of a unique timing factor — a sudden, substantial increase in licensing fees — AZ launched the "Empower" program through which ECE facilities earned official endorsement and, if applicable, a 50% fee reduction for voluntarily implementing 10 nutrition, physical activity, and tobacco prevention practices. The overwhelming positive response to the program, including the high participation rate among providers without financial incentive (e.g., those not up for licensure renewal), led to the formal incorporation of four Empower standards into licensing regulations. In addition, program participation was made an eligibility requirement for AZ's Quality Rating Improvement System. Stakeholders support providers through the state's technical assistance networks and pre-service and professional development system. Trainings are offered for CEUs and a set of online resources, including videos that showcase Arizona providers modeling the Empower standards, are available. A multi-agency Memorandum of Understanding is underway to ensure consistent messaging for the Empower program across state agencies. For additional information, go to: <<http://azdhs.gov/empower-program/index.htm>>.

California

CA's Healthy Beverages in Child Care Act, passed in 2010 with implementation in 2012,¹⁶ requires standards for all licensed ECE facilities including providing low-fat or nonfat milk for children 2 years and older, limiting serving of 100% fruit juice to no more than once per day, eliminating beverages with added sweeteners (natural or artificial), and making drinking water available to children at all times. Survey data collected from a random sample of ECE providers in 2012 identified barriers associated with the changes including: child preference; fear that children would drink less milk; food sourcing issues (e.g., facilities that source from schools may not have options other than flavored milk); needing many kinds of milk to accommodate different age groups and dietary/allergy issues and serving the correct milk to each child for providers who serve all age groups; and parents bringing disallowed beverages into ECE facilities. Providers reported encouraging healthy beverages by: prohibiting adults to drink disallowed beverages around children; not allowing beverages from home; educating parents and children about healthy beverages; and serving only healthy beverages. Several stakeholder groups disseminated information and offered training and technical assistance to providers on the bev-

erages requirements prior to implementation of the Act. Preliminary data suggest that beverage practices have improved between 2008 and 2012 as a result of the Act. For additional information, go to: <<http://healthybeveragesinchildcare.org/>>.

Delaware

DE's efforts have focused on standards for nutrition, physical activity, and screen time and thus far, have pursued action through most opportunities on the Spectrum. An advisory group crafted recommendations for enhanced licensing regulations, and the state's CACFP leadership enhanced their program requirements to align with best practice recommendations, which had a sweeping impact due to the fact that DE's regulations require all licensed providers to meet CACFP standards regardless of program participation. Licensing improvements for centers and homes were made and a QRIS was established through which health promotion and obesity prevention training and technical assistance is offered. Stakeholders developed several new toolkits,¹⁷ to help providers implement health promotion and obesity prevention standards and created spread and sustainability by the following: establishing a university-based statewide program; incorporating standard materials into existing, ongoing trainings (e.g., required CACFP trainings, orientation for newly licensed providers); updating curricula for community college ECE degree programs; updating the core competencies of DE's early learning standards; and creating a toll free assistance hotline. In-depth trainings using a "learning collaborative" model, which brought together small teams of ECE providers to talk through barriers and action plan, were also held. New online trainings and a health credential for providers are being pursued. For additional information, go to: <<http://www.nemours.org/content/dam/nemours/www/filebox/service/preventive/nhps/inthenews/obesitybattle.pdf>>.

New York State

NY's efforts are guided by a task force affiliated with the state's Early Childhood Advisory Council, and align with the state's overarching "Eat Well, Play Hard" (EWPH)¹⁸ childhood obesity prevention strategies, which encompass fruits/vegetables, milk, physical activity, breastfeeding, and screen time. NY's CACFP program embraced the EWPH strategies by encouraging voluntary compliance; incorporating them into their routine training and technical assistance; and highlight which foods supported the strategies in the program's food guidance document. Following a review of menu data, the CACFP program moved to institutionalize changes in the state's menus by creat-

ing the "Healthy Infant and Healthy Child Meal Patterns." NY also improved licensing regulations and provider training requirements, incorporated standards into QRIS, and integrated obesity prevention into the state's competency domains for early childhood educators (Core Body of Knowledge), which is the foundation for ECE professional development and performance. NY launched a multi-component, facility-level intervention for centers and homes, EWPH in Child Care¹⁹ that is administered by regional child care resource and referral agencies and in 37 counties. The intervention includes a 10-lesson preschool curriculum, parent handouts, pre- and post-assessment tools, and a staff training curriculum. NY has also supported statewide implementation of the Nutrition and Physical Activity Self Assessment in Child Care (NAP SACC)²⁰ intervention, which they augmented with a media reduction module. NY officially recognizes centers and family homes that meet a prescribed set of breastfeeding support practices through a "Breast-Friendly Child Care" initiative.²¹ A variety of training and technical assistance for obesity prevention occurs across the state through regularly scheduled activities, such as CACFP monitoring visits. On-demand trainings are available through the state sponsored online Early Childhood Education and Training program. For additional information, go to: <<http://www.health.ny.gov/prevention/nutrition/cacfp/ewphccs.htm>>.

Ohio

Efforts in OH began at the local level with a modest facility-level intervention (Healthy Children, Healthy Weights)²² initiated by the Columbus Public Health Department (CPHD). This intervention evolved into "Ohio Healthy Programs" (OHP) through a partnership with the Ohio Child Care Resource and Referral Association with funding provided by the Ohio Department of Health. Through OHP, providers earn state endorsement through four steps: (1) completion of trainings; (2) implementation of a health policy; (3) compliance with menu requirements; and (4) family engagement. A statewide trainer network conducts the required trainings, which are approved for CEUs and for OH's QRIS and monitored through an online registry. The CPHD recruits locally for OHP and provides onsite technical assistance including: (1) environmental assessment; (2) menu assessment; (3) parent and policy handbook review; and (4) training assistance. CPHD also offers incentives via vouchers that can be redeemed for nutrition and physical activity products and equipment. Centers receive increments of \$100 vouchers for meeting menu standards, for each health policy made (up to 3), and for earning

the OHP designation. For additional information, go to: <<http://occrpa.org/ohp.php>>.

Rhode Island

RI stakeholders, led by a diverse statewide partnership, developed a formal state plan²³ that serves as a call to action for policymakers, government representatives, parents, ECE providers, and community members to improve nutrition, breastfeeding, physical activity, and screen time policies and practices through licensing, QRIS, early learning standards, professional development, and technical assistance. To guide efforts, RI conducted a phone survey of ECE directors regarding knowledge of and barriers to achieving the national Let's Move! Child Care (LMCC) obesity prevention goals. RI stakeholders are working to help ECE providers achieve the LMCC goals, and a formal evaluation of these efforts is underway. For additional information, go to: <<http://www.health.ri.gov/publications/actionplans/2011EatSmartMoveMoreEarlyCare.pdf>>.

South Carolina

In 2008, SC collaborated with the Department of Social Services ABC Child Care Program, the state's quality improvement system (QIS), on a pilot project to implement NAP SACC²⁴ in 5 child care centers. This project provided a foundation for establishing nutrition and physical activity standards in the ABC Child Care Program. The standards (known as "ABC Grow Healthy") were adopted into all levels of the QIS, effective October 1, 2012. To support providers in the implementation of the new standards, the state's technical assistance networks and health department staff provide onsite assistance and trainings at early childhood conferences. The Eat Smart, Move More, Grow Healthy toolkit, developed in the Division of Nutrition, Physical Activity, and Obesity, is being offered to assist providers. The toolkit contains an assessment inclusive of the ABC Grow Healthy standards, sample menus and recipes, and sample policy documents. For additional information, go to: <http://abcqualitycare.org/pages/grow_healthy>.

Wisconsin

Efforts in Wisconsin began as a small partnership with state agency staff that ultimately grew into the "Wisconsin Early Childhood Obesity Prevention Initiative" (WECOPI), engaging over 500 partners. WI's efforts were informed by a comprehensive formative assessment of the early care and education (ECE) setting. To date, WI has expanded licensing commentary on nutrition and physical activity, included obesity prevention in QRIS, and developed two facil-

ity-level interventions ("Active Early" and "Healthy Bites"), which are being disseminated and evaluated through a CACFP wellness grant and Active Early pilot sites. Additionally, WI has developed "Got Dirt?", a garden toolkit and curriculum for onsite youth food gardens, and "10 steps to Breastfeeding Friendly Child Care Centers." WI also supports a network of highly-qualified trainers who deliver obesity prevention interventions to ECE providers, and has obtained \$2.7M in funding from federal and state sources specifically for obesity prevention in ECE. For additional information, go to: <<http://www.dhs.wisconsin.gov/physical-activity/Childcare/index.htm>>.

Community-Level Initiatives Presentation Summaries

Jefferson County, Alabama

The Jefferson County Healthy Action Partnership is successfully pursuing a multi-pronged effort that includes regulations, facility-level interventions, technical assistance, training, financial incentives, and a media advocacy campaign to activate parental demand for higher quality ECE programs using television, radio, billboards, and mailers. The county adopted regulations that require health and safety inspections for all legally operating centers, and include physical activity, nutrition, screen time, tobacco control, and training requirements and created a referral system for technical assistance and other resource needs. ECE centers had the opportunity to receive the CATCH curricula²⁵ and voluntarily participate in the NAPSACC intervention,²⁶ which tailored physical activity and nutrition training and technical assistance. Participating centers that exhibited leadership and high need were competitively awarded playground equipment, which was built and installed by local community and business volunteers. For additional information, go to: <http://www.cdc.gov/CommunitiesPuttingPreventiontoWork/communities/profiles/both-al_jefferson-county.htm>.

Chicago

An interdepartmental government task force set a policy agenda for a coordinated approach to Chicago childhood obesity prevention that included strengthened standards to improve ECE center beverage, physical activity, and screen time practices.²⁷ Implementation of the new standards began with a phase-in period during which the changes were not widely disseminated. A study was conducted during this period among facilities in communities with high expected obesity rates. The study examined effects of the new standards and a one-hour training intervention. No significant changes were observed. Preliminary find-

ings indicated that most center nutrition practices met the new standards at baseline, with the exception of serving low-fat milk. Children received an average of 45 minutes of moderate to vigorous physical activity; 60 minutes including light activity, though centers' physical activity practices varied. Unstructured play was associated with higher activity levels. Staff who received the training suggested improvements focused on more training opportunities, including web-based and on-demand trainings; more handouts to aid instruction; and more physical activity training. Center-level policies were identified as facilitat-

quently. Children's duration of moderate to vigorous physical activity varied based on centers' characteristics (e.g., access to outdoor play space) and training. Centers generally did not report any financial burden associated with implementing the regulations. For additional information, go to: <<http://www.centertrt.org/?p=intervention&id=1108>>.

Conclusion

The WON ECE Track sought to focus attention on and discuss national, state and community obesity prevention efforts targeting children birth — 5 years in the ECE

The ECE setting remains a vital place for early obesity prevention and the development of healthy habits for youth. The identification of obesity prevention standards for the ECE setting has helped to catalyze efforts across the country. While progress is being made, there is still a critical need for the adoption and implementation of obesity prevention recommendations. Future efforts should place emphasis on equipping ECE providers with the necessary training, technical assistance, and resources to implement obesity prevention recommendations on the ground level.

ing compliance with the new standards, as was access to high quality food vendors, meal preparation and activity space, staff and parent support. Identified barriers included lack of space, equipment, resources and training. Findings suggest that policy change, even accompanied by brief education sessions, may not be enough to support successful implementation. For additional information, go to: <<http://www.clocc.net/>>.

New York City (NYC)

In 2006, NYC acted on their authority to enact ECE regulations by improving standards for child care centers regarding beverages, physical activity, and screen time.²⁸ The changes were disseminated through public meetings, mailers to licensed centers, and routine site visits. The NYC Department of Health and Mental Hygiene supported implementation of the regulations by funding focused trainings, which served over 14,000 center staff (representing >80% of all centers), and providing free equipment and manuals. Evaluation results indicate that most centers were compliant. Difficulty in being compliant often stemmed from confusion (e.g., mistaking fruit drinks to be 100% juice) or not engaging in sufficient physical activity. Children in centers that met the beverage regulations consumed unhealthy beverages less fre-

quently. Children's duration of moderate to vigorous physical activity varied based on centers' characteristics (e.g., access to outdoor play space) and training. Centers generally did not report any financial burden associated with implementing the regulations. For additional information, go to: <<http://www.centertrt.org/?p=intervention&id=1108>>.

setting with the purpose of spreading what works and the valuable lessons learned from those on the ground. Presentations illustrated how a spectrum of opportunities for improved nutrition, physical activity, breastfeeding support, and screen time policies and practices had been pursued successfully in several states and communities, as well as support by national initiatives. Across the board strong leadership and collaboration among a broad group of ECE stakeholders; systematic assessment of needs, opportunities and resources; funding sources; and obesity prevention training and professional development were identified as integral to the successful development and implementation of policies and best practices, and sustainability.

The ECE setting remains a vital place for early obesity prevention and the development of healthy habits for youth. The identification of obesity prevention standards for the ECE setting has helped to catalyze efforts across the country. While progress is being made, there is still a critical need for the adoption and implementation of obesity prevention recommendations. Future efforts should place emphasis on equipping ECE providers with the necessary training, technical assistance, and resources to implement obesity prevention recommendations on the ground level. The Spectrum outlines a set of options that have been successfully used for ECE obesity prevention

efforts. CDC is committed to providing ongoing technical assistance and supporting training for obesity prevention efforts targeting the ECE setting. Additionally, a compilation of obesity prevention interventions targeting ECE that have been evaluated for level of evidence (e.g., research-tested, practice-tested, or emerging) can be found at: <http://www.centertrt.org/?p=interventions_interventions_overview>.

Note

The findings and conclusions in this report are those of the authors and do not necessarily reflect the official position of the Centers for Disease Control and Prevention.

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